healthy connections

Primary Care Providers Practice Information

All Primary Care Providers/Clinics

Date:_____ Region #_____ County:_____ Completed By:_____

This information may be disclosed to the public pursuant to the Administrative Procedures Act if written request received.

Release of Information Discussed?:_____ Provider Representative_____

Idaho Medicaid Provider? □ Yes □ No HC Provider? □ Yes □ No Multiple Clinics/Offices? □ Yes □ No

Clinic/Practice Name:_____ **Practice Address:**_____

City:_____ State:_____ Zip:_____ Phone Number: ( )_____-_____

Mailing Address if Different from Above:_____

Total Number of Practitioners in Office:___ Total PCPs:____ Total NPs:____ Total PAs:____ Total Specialists:____

Office Parameters

□ Open Practice to Medicaid Clients □ Unlimited Number of Medicaid Patients Accepted Per Month:_____

□ Closed Practice to Medicaid Clients □ Existing Medicaid Only □ OB Services □ Delivery Services

Gender Restrictions: □ None □ Female Only □ Pregnant Female Only

Age Restrictions: □ None □ Adults Only—From____to____Years □ Children Only—Up to_____Years

Other Restrictions: □ Families Only □ Other_____

Office Hours

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
____to____ □ Closed	____to____ □ Closed	____to____ □ Closed	____to____ □ Closed	____to____ □ Closed	____to____ □ Closed	____to____ □ Closed

Special Accommodations

Optional

□ Wheelchair Access □ TDD Phone Number ( )_____-_____

Interpretive Services: □ Sign Language □ Spanish □ Other Languages Specify:_____, _____

Interpretive Language Services Are: □ Contracted □ Provided by Staff □ Provided by Other_____

Additional Information Required For Healthy Connections PCPs

Healthy Connections Effective Date:_____ □ HC is Mandatory in Practice

HC Referral Number: □ Individual Provider Reference No._____ □ Clinic/Group Reference No._____

Administrative Phone Number: ( )_____-_____ Fax Number: ( )_____-_____

Office Manager's Name:_____

Certificate of Liability on File: □ Yes □ No Expiration Date of Liability Coverage:_____

Practice is a (n): □ Corporation □ Partnership □ Solo □ RHC □ FQHC □ HIS

After Hours Coverage Taken By:

□ Answering Machine Which Directs Patients to a Medical Professional

□ Answering Service □ On Call Physician □ On Call Nurse □ Other: _____

Continued on Reverse Side→

Individual Provider Listing For This Group Practice

Provider Name	Individual Referral Number Used (For HC Providers Only)	Specialty	Board Certified or Board Eligible	*Admit Privileges	**Delivery Services or Arrangements	Accepts New Non-Medicaid Patients	Accepts New OB Patients	# New Medicaid per Month	% Clinic Hours on Medicaid	% Clinic Hours on Migrant, Seasonal, Farm Laborer	Total Clinic Hours Per Week
Primary Care Physicians (providing primary care)											
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
11.											
Mid-Level Practitioners (PAs, NPs, etc.)											
12.											
13.											
14.											
15.											
16.											
Specialists (not providing primary care)											
17.											
18.											
19.											

***Identify which hospital(s) this provider has admitting privileges at:** Phys:___, Hosp:_____, Phys:___, Hosp:_____,
Phys:___, Hosp:_____, Phys:___, Hosp:_____, Phys:___, Hosp:_____, Phys:___, Hosp:_____, Phys:___, Hosp:_____
Phys:___, Hosp:_____, Phys:___, Hosp:_____, Phys:___, Hosp:_____, Phys:___, Hosp:_____, Phys:___, Hosp:_____

****Identify who this provider has "Delivery Arrangements" with:** Phys: ___, Other: _____, Phys: ___, Other: _____,
Phys:___, Other:_____, Phys:___, Other:_____, Phys:___, Other:_____, Phys:___, Other:_____, Phys:___, Other:_____